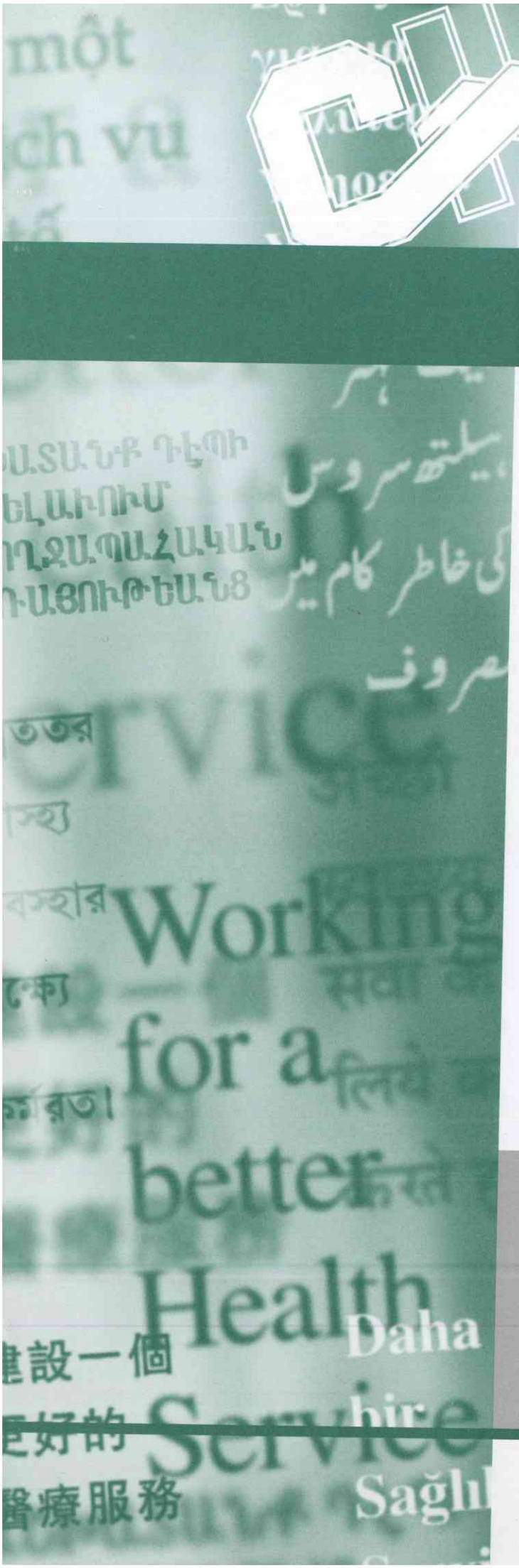

Elevating LIFT

The Improvement of a Concept - Through Patient and Public Involvement in Health.

How local Community Health Councils and the Association of Community Health Councils for England & Wales worked together on developing LIFT.

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Association of
COMMUNITY HEALTH COUNCILS
for England & Wales

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1. Introduction.

Local citizens want health care that is accessible, effective and responsive. The Government has emphasised the role of integrated primary and community services to respond to this.

Primary care premises are, however, often inaccessible and inappropriate for modern health care. Only a minority are purpose-built, with many in converted residential buildings or former shops. These limit the nature and quality of services provided for local people, and their accessibility.

The NHS has always given priority to hospitals in estates development. Investments in primary care facilities have tended to be piecemeal. Yet, it is here that the majority of health care is actually provided, with particular importance in the areas of greatest deprivation and health inequality.

The Government's response in the NHS Plan for England (2000) was a new public-private partnership – the NHS Local Improvement Finance Trust (NHS LIFT). It stated that NHS LIFT and public capital would lever £1 billion investment in the primary care estate to deliver by 2004 not only substantial upgrades or replacement of up to 3000 primary care premises but also 500 one-stop primary care centres.

The NHS Plan said that the priority would be investment in those places where health need is greatest. These tend to have the biggest shortages of primary care practitioners, and a disproportionately high number of poor primary care premises that are most in need of improvement and expansion.

Responding to the listening exercise on involving patients and the public in health care (2001), the Government stated that it wanted *"to move away from a system of patients being on the outside, to one where the voices of patients, their carers and the public generally are heard and listened to through every level of the service, acting as a lever for change and improvement."* Yet, NHS LIFT is at risk of failing to deliver on a commitment that is at the heart of the NHS Plan.

There is a new raft of statutory arrangements being introduced for patient and public involvement (PPI) in the NHS, but with little or no explicit reference to their relationship with public-private partnerships (PPPs). There is a lack of national guidance on this for either PPI or PPPs

No mention has been made at national level of local people being regarded as stakeholders or potential shareholders in NHS LIFT. This implies that NHS LIFT would have no public involvement and no direct accountability to the citizens for whom the facilities and services ultimately exist. Indeed, the Department of Health states that the NHS (and GPs) will have the central role in determining where investments are made, and will share in any profits.

If NHS LIFT is the chosen way through which to deliver better primary care facilities, patients, carers and the public have their expertise to offer and should have a real and direct influence over its development. The current model can be improved to realise this.

As LIFT at local level is expected to use national model documents, it is as important that changes are made at national level, as well as action being taken at local levels. This briefing raises issues and offers some means towards practical implementation.

2. NHS LIFT.

The NHS Local Improvement Finance Trust (NHS LIFT) is intended to encourage and develop a new market for investment and development in primary care and community-based facilities and services. It is a national joint venture between the Department of Health and Partnerships UK plc (PUK), which aims to:

- help improve the primary care estate
- own and lease premises through local LIFT companies to primary care practitioners
- empower and assist the regeneration of local communities by providing better healthcare facilities, and involving local businesses to deliver local solutions

NHS LIFT is a form of public-private partnership distinct from the private finance initiative (PFI), with which it is often confused. Each LIFT company (LIFTco) is a joint venture company limited by share capital. The local NHS (mainly primary care trusts), local authorities, Partnerships for Health (PfH) and the private sector are shareholders, and share profits made. Each private sector partner is identified through competitive procurement.

It is intended that, at a local level, a management board comprising representatives from these sources will run LIFT and decide its investment programmes. This might include individual practitioners, although no specific reference is made to those other than GPs, and there is not a single mention of local people.

The six first-wave LIFT schemes were announced in 2001, with 12 in the second wave in 2002, and a further 24 in the third wave of 2003.

There is significant public concern and some suspicion about public-private partnerships. The Government claims that the additional local benefits of the NHS LIFT approach are flexibility for GPs, scale and speed of delivery, and the integration and co-location of services. Some people feel, however, that some benefits claimed for LIFT could be achieved equally well by other means. There are questions about the long-term cost-effectiveness of LIFT and whether the NHS will end up spending much more on new facilities than it needs to. Some people would prefer direct public sector investment to revitalise health care facilities.

3. Openness and confidentiality.

It is vital from a lay perspective that all information held by public or private sector partners is open in public, except where this would significantly prejudice commercial interests.

Patient and public involvement forums.

In line with Section 19(2)(k) of the NHS Reform and Health Care Professions Act 2002, Regulation 5 of the Patients' Forums (Functions) Regulations 2003 places a duty to comply promptly and within 20 working days to a request by a patients' forum for information necessary to carry out its functions on: strategic health authorities; NHS trusts; primary care trusts; the Commission for Patient and Public Involvement in Health; providers of independent complaints advocacy services; and other patients' forums.

The only restrictions on this, under Regulation 6, cover:

- information that is confidential and relates to a living individual, unless either it can be disclosed in a form from which the identity of the individual cannot be ascertained, or the individual consents to the information being disclosed
- information that is prohibited from disclosure by or under any enactment or is protected by the common law, unless either the prohibition arises because the information is capable of identifying an individual, or the information can be disclosed in a form from which the identity of the individual cannot be ascertained.

Overview and scrutiny committees.

The Health and Social Care Act 2001 and the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 provide for local authority review and scrutiny of the NHS. This applies to NHS trusts, PCTs and strategic health authorities.

Regulation 5 of the 2002 Regulations places a duty on local NHS bodies *"to provide an overview and scrutiny committee with such information about the planning, provision and operation of health services in the area of that committee's local authority as the committee may reasonably require in order to discharge its functions"*, except confidential information that is about and identifies a living individual (unless they consent).

Exempt information.

Section 9 of the Health and Social Care Act 2001 relates to items at overview and scrutiny committee (OSC) meetings, with information specified in Schedule 1 as being exempt under section 100A(4) of the Local Government Act 1972. There are three stages for LIFT at which exempt information needs to be considered:

1. Confidentiality clauses in contracts between private partners, NHS bodies and consortia. The model agreement for NHS LIFT permits the partners to withhold key information. Paragraph 29 of the LIFT Partnering Agreement defines confidential information as, *"all information relating to one party which is supplied by or on behalf of that party . . . or which is obtained through observations made by the receiving party."* There follow several narrow exemptions, such as where information must be disclosed by law, is already in the public domain or is voluntarily issued by the party

concerned. The basic assumption is, however, that all information pertaining to LIFTco is confidential unless agreed otherwise.

The Code of Practice on Access to Government Information states the Government's intention as being, *"to improve policy-making and the democratic process by extending access to the facts and analyses which provide the basis for the consideration of proposed policy."*

In similar fashion, the Code of Practice on Openness in the NHS requires the provision of information relating to:

- *"details about important proposals on health policies, or proposed changes in the way services are delivered, including the reasons for those proposals. This information will normally be made available when proposals are announced and before decisions are made*

- *details about important decisions on health policies and decisions on changes to the delivery of services. This information and the reasons for the decisions will normally be made available when the decisions are announced".*

The effect of imposing a blanket confidentiality clause such as that proposed by Partnerships for Health is to remove this information from the scope of the Codes of Practice. This might be replaced in local agreements with a clause balancing the provision for openness with specific protections for confidentiality where disclosure may cause harm. An example of such is in the Code of Practice on Access to Government Information, which exempts *"commercial confidences, trade secrets or intellectual property whose unwarranted disclosure would harm the competitive position of a third party."*

In similar fashion, when it comes into force, Section 43(2) of the Freedom of Information Act provides an exemption where disclosure *"would, or would be likely to prejudice the commercial interests of any person".*

2. The Public Bodies (Admission to Meetings) Act 1960 allows NHS bodies to consider in private matters where they consider that *"publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted".* This can be, and has been, interpreted widely.

3. Overview and scrutiny committees, being part of local government, have to organise their business in line with the provisions of the Local Government Act 1972. When considering information relating to health services, overview and scrutiny committees will *only* be able to consider matters in private if they fall within one of the exceptions provided for in Schedule 1 of the Health and Social Care Act 2001.

<u>Implications.</u>

Given the remit of PPI forums, the information to be provided to them appears to encompass that about PPP arrangements into which NHS bodies have entered. Similarly, the remit of OSCs includes plans for and the operation of private sector and PPP arrangements into which NHS bodies have entered.

It will be important to monitor whether PPI forums or OSCs have trouble in obtaining information, particularly in view of the confidentiality clauses in model contracts for NHS LIFT.

Rights and responsibilities should be incorporated into LIFT mechanisms at local level. It is somewhat unclear what the implications might be for different organisations within LIFT:

- local NHS agencies will have to fulfil their statutory duties
- it needs to be clarified what information from LIFT Strategic Partnering Boards must or should be provided
- LIFT companies and private partners are likely to be bound only by any local contractual arrangements that are agreed.

4. Patient and public involvement.

Duty to involve patients and the public.

Section 11 of the Health and Social Care Act 2001 makes it a statutory duty of NHS trusts, primary care trusts and strategic health authorities to make arrangements to secure the involvement and consultation of patients, carers and the public on:

(a) planning the provision of services
(b) development and consideration of proposals for changes in the way those services are provided
(c) decisions to be made by that body affecting the operation of those services.

Services covered by this include those provided by:

(a) NHS trusts, primary care trusts and strategic health authorities
(b) other persons for any such NHS body:
    (i) at that body's direction
    (ii) on its behalf, or
    (iii) under an agreement or arrangements made by that body with that other person
(c) any such NHS body jointly with another.

This statutory duty is supported by policy and practice guidance - Strengthening Accountability. Involving Patients and the Public (2003) – which makes no reference to PPPs.

PCT patient and public involvement forums:

Sections 16(3) and (4) of the NHS Reform and Health Care Professions Act 2002 make it the function of PCT patient and public involvement (PPI) forums, with regard to consultations or processes leading (or potentially leading) to decisions by, and the formulation of policies by, a range of agencies, which would or might affect the health of the public:

(a) to promote the involvement of the public in the PCT's area
(b) to make available advice and information to such members of the public about such involvement
(c) to advise those agencies involved about how to encourage such involvement (including on fulfilling Section 11 of the Health and Social Care Act 2001)
(d) to monitor how successful those agencies are at achieving such involvement.

The agencies to which this relates are: PCTs, NHS trusts providing services in each PCT's area, strategic health authorities, other public bodies, and others providing services to all or a section of the public.

Independent complaints advocacy services.

Section 12 of the Health and Social Care Act 2001 places a duty on the Secretary of State to arrange for the provision of independent advocacy services to provide assistance to individuals wishing to make a complaint through formal procedures about matters under the auspices of a health service body or an independent provider. Section 16(1)(a) and (b) of the NHS Reform and Health Care Professions Act 2002 makes it a function of PCT PPI forums to provide information and advice about making complaints, and to provide such independent advocacy services to people in the PCT's area or those to whom services have been provided by, or under arrangements with, the PCT.

The definition of independent provider is taken from the Health Service Commissioners Act 1983 (as amended): *"persons (whether individuals or bodies) providing services in England under arrangements with health service bodies or family health service providers".*

ICAS services have a statutory function to support individuals with complaints about non-statutory providers of services to PCTs, NHS trusts, PCTs, primary care practitioners and strategic health authorities. This includes private sector and PPP arrangements into which NHS bodies have entered.

Implications.

Specific provisions for involvement and consultation within NHS LIFT are limited to early stages of development. Consultation must take place during the development of the Strategic Service Development Plan (SSDP), which in the first year occurs before the selection of the private sector partner. The extent and nature of such consultation in local NHS LIFTs to date has been variable.

The SSDP is a general statement of purpose. The actual decisions on what premises are bought, built or upgraded and which services will be in each premises occurs through a process of approving new projects. If involvement and consultation merely occur at the stage of drawing up the SSDP, local NHS agencies will fail to fulfil their statutory duty under Section 11.

Local NHS bodies must, however, ensure the involvement and consultation of patients, carers and the public on the planning, development and consideration of proposals and decisions affecting services provided by private sector and PPP arrangements into which NHS bodies have entered.

Similarly, the remit of PCT PPI forums and ICAS services appear to encompass private sector and PPP arrangements that NHS and other public bodies have entered into.

There is, however, no specific guidance on how this should be done, or what the implications might be for LIFT Strategic Partnering Boards, LIFT companies or private partners. It would, however, be appropriate for PCT PPI forums to have:

- early involvement in the development of LIFT
- a role in selecting the private partner
- a place on the Strategic Partnering Board, with speaking rights.

The lead of the Manchester, Salford and Trafford LIFT might also be followed to ensure direct community shareholding in each LIFT company – perhaps through an independent not-for-profit organisation or charitable trust – with a place on the Strategic Partnering Board.

It would also be advisable to ensure incorporation of a clause into LIFT contracts and policies to require:

- the private partner to support the statutory bodies to fulfil their duties for involvement and consultation of patients and the public
- the development of local / social governance and ownership within of individual LIFT schemes

5. Conflicts of interest.

With so many interests represented the potential for conflict is manifest – despite any common goals that may have been identified in principle. These are some of the conflicts that may arise.

Upmarket versus downmarket location of services.

Targeting health care where it is most needed should favour deprived areas. If, instead, the overriding objective is to maximise revenue generation from associated commercial uses, sites in more affluent areas may be favoured. Consequently, there may be conflicts between the priorities of the private and public sectors.

Integrated services versus local accessibility.

There are clearly advantages – both for private sector interests and service users – in providing large premises with a number of services available together under one roof. It is possible that any enhanced opportunities of revenue generation afforded by creating such sites may discourage the private sector from taking full account of any inconvenience due to longer journeys and potential inaccessibility.

Community centres versus commercial outlets.

Potential for conflict also exists when decisions have to be made about which services will be located in the premises. Local health care strategies may, for example, favour the use of space for Alcoholics Anonymous meetings, whereas the LIFTco may prefer to lease it out for commercial use to maximise profits.

LIFTco will have the power to make critical decisions affecting the local health economy. One way to balance this is to make profits dependent upon specified outcomes, such as health or social impact (assessed perhaps through social audit) or levels of service user, tenant and staff satisfaction.

6. Private sector accountability.

LIFTco membership.

LIFTco is a joint venture company made up of the local NHS bodies, local authorities, the private sector partner and Partnerships for Health. There is an in-built disparity of power between the private and public sector partners. The company will have five directors, three of which will be nominated by the private partner, one jointly nominated by the public sector partners, and the other a nominee of Partnerships for Health. Decisions will be made by a simple majority vote. The private sector partner will therefore always have effective control.

Exclusivity of the contract.

Paragraph 9 of the Partnering Agreement outlines the exclusive nature of the relationship between LIFTco and the Participants, stating that *'LIFTco shall have the sole, exclusive right to provide the Partnering Services to the Participants on the terms and subject to the conditions of this Agreement.'*

Under Schedule 17, Partnering Services are listed as including *"membership of strategic partnering board, estate management, service planning, estate planning, property development, supply chain management, long term value for money and collaborative working"*. This exclusivity clause might be modified so that it does not apply to partnering services, and especially not to any that effectively entail policy advice, especially if this concerns the feasibility of putting certain services in certain areas and how projects will be 'bundled' together.

New projects.

Schedule 4 of the Partnering Agreement outlines the approval process for new projects. LIFTco's obligations include *"work[ing] with"* the participants throughout this process. This is not defined, although LIFTco may provide partnering services (as detailed in Schedule 17) to help participants in the approval process. These could be anything from service planning to architectural advice.

LIFTco has no vote in the approval of new projects. This may, however, not adequately safeguard the ability of public sector partners to ensure decisions are in the public interest. For example, the local health economy may want small centres in residential areas to ensure that those who have difficulty travelling great distances can have easy access to GP and other services. It is possible that LIFTco may say this is not financially viable and would prefer to build a large integrated service out of town. The Strategic Partnering Board (SPB) would be unable to get independent advice. If it rejected proposals the SPB could be liable to pay the costs LIFTco incurred in their preparations. The cumulative effects of these clauses may leave the SPB with little real power or influence in the decision-making process.

Transferability.

The private sector partner can in effect sell their part of the business to other individuals or companies, so damaging any protection gained during the selection process. Private companies are frequently taken over by large corporations and there is no guarantee that the aims or ethos of the latter will be in harmony with the public interest.

There are several ways in which the public sector partners may seek to protect their interests. These include:

- inserting an express provision imposing any necessary contractual obligations on any replacement private sector partner
- having an express right of veto attached to the class of shares held by the public sector, and/or
- the adoption by the new partner of a specific corporate policy.

7. Public accountability.

Shareholders' Forum.

There is no explicit scope within the national model documentation for independent scrutiny of NHS LIFT. The Shareholders Agreement establishes a Shareholders Forum of representatives from each of the shareholders. Although the Forum will have a reviewing and reporting function, it has no power and may have limited access to information. Moreover, the partners will effectively be scrutinising themselves, unless additional arrangements are made, such as the community shareholding arrangements described in section 4 above.

It is therefore critical that there is active independent local monitoring and scrutiny of NHS LIFT and the use of public money through it.

Patient and public involvement forums.

Section 15(3) and (4) of the NHS Reform and Health Care Professions Act 2002 places statutory duties on every patient and public involvement (PPI) forum to:

(a) monitor and review the range and operation of services provided by, or under arrangements made by, the trust for which it is established
(b) obtain the views of patients and their carers about those matters and report on those views to the trust
(c) provide advice, and make reports and recommendations, about matters relating to the range and operation of those services to the trust, having regard to the views of patients and their carers
(d) make available to patients and their carers advice and information about those services.

In line with Section 17 of the Act, Regulation 3 of the Patients' Forums (Functions) Regulations 2003 gives people authorised by a PPI forum the right at any reasonable time to enter and inspect premises (except staff residential accommodation) owned or controlled by:

- in the case of a PPI forum established for an NHS trust, that NHS trust,
- in the case of a PPI established for a PCT, relevant PCTs, local authorities and NHS trusts; and primary care contractors (dentists, GPs, optometrists, pharmacists) and those who own or control premises where their services are provided.

The only exception to this is where such entry or inspection would compromise the effective provision of health services or patients' safety, privacy or dignity.

In line with Section 19(2)(p) of the Act, Regulation 8 of the Patients' Forums (Functions) Regulations 2003 places a duty on each PPI forum to prepare and produce a report of each review it makes to: the NHS trust or PCT for which it established; any other body or person that provides the services reviewed; the provider of any ICAS service mentioned; the relevant strategic health authority; any other PPI forum involved in the review; the Commission for Patient and Public Involvement in Health; and anyone else requesting a copy of the report.

These provisions mean that if services are provided by a private partner or any of the bodies involved in NHS LIFT, either individually or jointly, the PPI forum remit and duties will extend to those services, including:

- contractual arrangements between the parties for the provision of those services

- the right of entry and inspection to all premises where primary care services are provided and those wholly or partially owned or controlled by local authorities, local NHS bodies and primary care practitioners – thus including all NHS LIFT buildings, except residential accommodation of staff and practitioners

- provision and publication by local NHS bodies of comments on PPI forum reports and recommendations that relate to private sector and PPP arrangements - such as NHS LIFT - that those bodies have entered into.

Where a PPI forum requests a response from the NHS trust or PCT to which it has made a report or recommendation, that trust must respond in writing promptly and within 20 working days, giving an explanation of any actions it intends to take or why it does not intend to take any action. This response may be published by the PPI forum as it considers appropriate.

Similarly, under sections 15(5) and (6) of the Act, every PPI forum will have the right to refer any matter, including about NHS LIFT, to an overview and scrutiny committee, the Commission for Patient and Public Involvement in Health or other bodies as it sees fit.

In addition, Regulation 7 of the Patients' Forums (Functions) Regulations 2003 enables a PPI forum – if it has made all reasonable efforts to resolve the matter but these have failed – to refer to a relevant OSC where it considers that the NHS trust or PCT for which it is established is not carrying out its duty under section 11 of the Health and Social Care Act 2001 to involve and consult patients and the public, or is not doing so in a satisfactory manner.

Overview and scrutiny committees.

The Health and Social Care Act 2001 and the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 provide for local authority review and scrutiny of the NHS. This applies to NHS trusts, primary care trusts (PCTs) and strategic health authorities.

Regulation 6 of the 2002 Regulations gives the power to overview and scrutiny committees (OSCs) to require an officer of a local NHS body to appear before the OSC to answer questions that it considers necessary to discharge its functions. The officer has a statutory duty to comply with this, given reasonable notice, and to provide information described in Regulation 5 (see section 3 above).

This requirement will include answering questions on plans for, and the operation of, by private sector and PPP arrangements into which NHS bodies have entered.

Following the principle set out in section 4.4.1 of Overview and Scrutiny of Health – Guidance (Department of Health, July 2003), it would be good practice for NHS bodies and local authorities to build clauses into their tendering documents and contracts with private sector partners in NHS LIFT requiring them, if requested, to provide information and to attend reviews at no cost to an overview and scrutiny committee.

The Act and Regulations also place a statutory duty on every local NHS body to consult an OSC where it *"has under consideration any proposal for a substantial development of the health service in the area of [the] local authority, or for a substantial variation in the provision of such service"*. Where an OSC considers that the proposal would not be in the interests of the NHS in its area, it may report to the Secretary of State in writing who may make a final decision on the proposal and require the local NHS body to take or desist from action, as he or she may direct.

An NHS trust, PCT or strategic health authority must therefore consult an overview and scrutiny committee on any arrangements with the private sector or through a PPP (including NHS LIFT) into which they have entered, where these involve a proposal for a substantial development or variation in services.

Finally, Regulation 3(3) of the 2002 Regulations places a duty on every local NHS body, when requested, to respond in writing within 28 days to a report or recommendation by an OSC. They will therefore have to respond to reports and recommendations from OSCs about private sector and PPP arrangements into which they have entered – including NHS LIFT.

Implications.

Given the above, it would be advisable to ensure incorporation of a clause into LIFT contracts and policies to require the private sector partner to support the statutory bodies in fulfilling their duties for accountability to the public within any prescribed time scales.

8. Summary.

Patient and public involvement in NHS LIFT.

"must do"	"should do"	"could do"
• Provide information to patient and public involvement forums (s.19 NHSR; regs. 5 and 6 PFFR) • Provide information to overview and scrutiny committees (reg. 5 HSF; LGA and sch. 1 H&SC) • Appearance and explanations at overview and scrutiny committees (reg. 5 HSF) • Public involvement and consultation (s.11 H&SC) • Consultation of overview and scrutiny committees (s. 7 H&SC; reg. 4 HSF) • Respond to patient and public involvement forum reports and recommendations (s.19 NHSR; reg. 8 PFFR) • Respond to overview and scrutiny committee reports and recommendations (reg. 3 HSF)	• Liaise with patient and public involvement forums (ss.15, 16 and 17 NHSR; regs. 3 and 7 PFFR) • Liaise with Independent Complaints Advocacy Service (s.12 H&SC; s.16 NHSR; HSC) • Provide information to and attend reviews by overview and scrutiny committees (s. 4.4.1 OSHG) • Requirement in plans and contracts for private partner to support patient and public involvement • Public and media communications	• Clause in local agreement to balance openness with protection for commercial confidentiality (cf. CPAGI; s. 43 FOI) • Local action groups / forums in centres or localities • Centre specific mission statements that include community involvement, ownership and consultation • Key performance indicators to reflect involvement, take-up and satisfaction • Local / social governance and ownership of schemes • Community shareholding

Key: CPAGI: Code of Practice on Access to Government Information
FOI: Freedom of Information Act 2000
H&SC: Health and Social Care Act 2001
HSC: Health Service Commissioners Act 1983
HSF: Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002
LGA: Local Government Act 1972
NHSR: NHS Reform and Health Care Professions Act 2002
OSHG: Overview and Scrutiny of Health – Guidance (Department of Health, July 2003)
PFFR: Patients' Forums (Functions) Regulations 2003

9. Glossary.

Partners.

- participants – primary care trusts, local authorities, some NHS trusts (e.g., ambulance, mental health)
- private sector partner – the private company or consortium engaged through competitive procurement to form the local LIFT company
- Partnerships for Health (PfH) – a joint venture company between the Department of Health and Partnerships UK to develop PPPs in the NHS
- Partnerships UK (PUK) – helps the Government deliver public–private partnerships, and to develop new forms of PPPs. PUK is itself a joint venture company with 49% public sector ownership (HM Treasury 44%; Scottish Executive 5%) and the private sector 51% (through a range of private sector companies and institutions).

Bodies.

- LIFT company (LIFTco) – the joint venture company set up to run a LIFT scheme, established between local NHS bodies, local authorities, Partnerships for Health and the private sector partner
- LIFT Board – the local LIFTco management board comprising private sector partners, local NHS nominees and PfH to agree and develop investment programmes
- Shareholders Forum – a forum consisting of all the shareholders of LIFTco
- Strategic Partnering Board (SPB) – the non-statutory forum consisting of representatives of the participants and other local interests (such as family practitioners and community organisations) to agree priorities for service development and improvement

Documents.

- Shareholders Agreement – partnership agreement which establishes LIFTco, the Shareholders Forum and their respective roles
- Strategic Partnering Agreement (SPA) – the contract which regulates LIFTco's implementation of the Development Plan and sets up the Strategic Partnering Board
- Strategic Service Development Plan (SSDP) – the annual LIFT plan against which Lift Co produces proposals for development.